CHAPTER VI

UTILIZATION REVIEW AND QUALITY MANAGEMENT REVIEW

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INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of services of providers and individuals. These reviews are mandated by 42 CFR §§ 455-456 and may be conducted by the Department of Medical Assistance Services (DMAS) or its designated agent.

The DMAS staff conduct quality management reviews (QMRs) on all programs. In addition, the DMAS Division of Program Integrity staff conduct compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals (12VAC30-120-1760).

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from the Department of Medical Assistance Services (DMAS). Under the Provider Participation Agreement with the DMAS (see Chapter II), the provider also agrees to give access to records and facilities to the DMAS representatives, the Attorney General of Virginia or authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization reviews, documentation requirements, and control requirement procedures conducted by the DMAS or its designee.

UTILIZATION COMPLIANCE REVIEW (UR) – DIVISION OF PROGRAM INTEGRITY

DMAS staff from the Division of Program Integrity or a DMAS designated contractor routinely conduct utilization compliance reviews (URs) to ensure that the services provided to Medicaid individuals are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 CFR, Part 455. Providers are identified for review by systems-generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.

DMAS staff or a DMAS designated agent review all cases using available resources, including appropriate consultants, and conduct on-site or desk reviews of medical and other individual and provider records as necessary.

The purpose of a utilization review conducted by Division of Program Integrity is to determine whether services delivered were appropriate, whether services continue to be needed, and the amount and kind of services required. Utilization review is mandated to ensure that the health, safety, and welfare of the individuals are protected and to assess the quality, appropriateness, level, and cost-effectiveness of care.

The use of statistical sampling may be used during a utilization review. The Department may use a scientific random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample is compared to the total invalid payments for the same time frame, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time frame.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or as a result of any of the above problems, Medicaid, as set forth in the Provider Agreement, may restrict, limit, suspend, or terminate the provider's participation in the program.

If the provider review results in an overpayment of funds that are due to DMAS, the Fiscal Division at DMAS will be contacted and will coordinate the collection of any payments due to DMAS. If the provider requests an appeal of the overpayment decision from the review, the provider must notify the Fiscal Division of the Appeal request.

DMAS analysts will conduct utilization review of all documentation submitted by the provider that shows the individual's needs, available social supports, and level of care. Utilization review is conducted on-site or as desk reviews and will most often be unannounced. The utilization review is accomplished through a review of the individual's record, evaluation of the individual's medical and functional status, review of the provider qualifications, consultation with the individual and family members, and a review of personnel records and the provider's billing records.

When the team arrives at the provider's place of business/offices, the team will request a minimum number of records per team member in order to begin the review process. The utilization review team will also request the provider to provide the rest of the records on the review list within two

(2) hours of their arrival time for open records and by close of business on the arrival day for closed records.

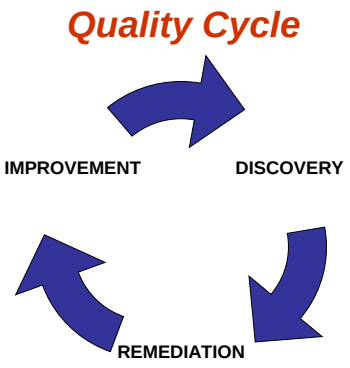
During an on-site review, the analyst will review the individual's record in the provider's/Service Facilitator's (SFs) place of business/offices, paying specific attention to Plan of Care, supervisory notes (RN) and (SF), daily records, progress notes, screening packages, and any other documentation that is necessary to determine if appropriate payment was made for services rendered. The DMAS analyst will also meet or talk with at least one individual or primary caregiver to determine individual satisfaction with the CCC Plus Waiver services and the provider. The provider may be asked to assist in setting up this visit. In all cases, the primary caregiver is encouraged to participate in the DMAS review of the individual's care.

During the review process, the analyst will be available to offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures. A letter will be sent to the provider in a timely manner after the review is complete to either document the results of the review or provide an update on the status of the review.

QUALITY MANAGEMENT REVIEWS (QMR) – DIVISION OF PROGRAM INTEGRITY

A typical QMR encompasses the follow elements:

Discovery: The review of documentation findings and individual interviews.



Remediation: Based on Discovery, the provision of technical assistance or provision of a corrective action plan ensure needed changes are implemented. Corrective action is taken by Provider to ensure compliance.

Improvement: The follow up activities to assure that recommended or mandated corrective action and/or improvements to service delivery have been initiated**.**

By federal law, DMAS is the single state authority responsible for the supervision of the administration of home and community-based waivers in the Commonwealth of Virginia and shall perform routine QMRs of waiver services and providers. QMRs are not to be confused with URs, which is a separate review, as described in this chapter.

When the team arrives at the provider's place of business/offices, the team will request a minimum number of records per team member in order to begin the review process. The QMR review team will also request the provider to provide the rest of the records on the review list within two (2) hours of their arrival time for open records and by close of business on the arrival day for closed records.

DMAS analysts with the Division of Integrated Care or its contractors shall conduct ongoing monitoring of compliance of a provider with DMAS participation standards and policies. QMR includes a review of the provision of services to ensure that services are being provided in accordance with DMAS regulations, policies, and procedures. A provider's noncompliance may result in a request for a corrective action plan, provision of technical assistance, and/or referral to the Division of Program Integrity.

DMAS analysts shall conduct QMRs of waiver services provided to ensure the health, safety, and welfare of the individual and individual satisfaction with services. The reviews shall focus on the Centers for Medicare and Medicaid's (CMS) assurances of health, safety and welfare, level of care determination, plan of care, and qualified providers, including individual preferences and choices, services being delivered in accordance with the plan of care and the identification of inclusion and risk. In addition to assessing the individual's ongoing need for Medicaid-funded home and community based services (HCBS), another purpose of the reviews is to ensure a waiver individual's satisfaction with waiver services and providers, and that individual choice of services and person-centered planning are being carried out.

During the on-site QMR review, DMAS analysts monitor the provider's compliance with overall provider participation requirements. Particular attention is given to qualifications of provider staff such as work references (or proof in the personnel file of a good faith effort to obtain such references) and documentation of criminal background checks within 30 days of the date of hire, as described in Chapter II of this manual. However, no employee shall be permitted to work in a position that involves direct contact with an individual in the waiver until an original criminal background record clearance has been received unless such person works under the direct supervision of another employee for whom a background check or CPS (Child Protective Service) check has been completed in accordance with the Code of Virginia. DMAS analysts will request to see health professionals' licenses, training certificates for personal care aides, etc. and required documentation that staff who have provided services meet all qualification requirements as identified in DMAS regulations and policies. The provider is responsible for ensuring that all staff of the provider meets the minimum requirements and qualifications at the start of the employment.

During the QMR, DMAS analysts will discuss with the provider's administration the provider's overall status as a Medicaid provider, any areas of concern, technical assistance needs, the plans for addressing those needs, and any recommendations that staff may have. DMAS may also

require additional documentation to verify that the provider is in compliance with DMAS provider agreements and policies, including requirements for ownership of provider agencies. It is the responsibility of the provider to know and fulfill all applicable state and federal requirements relating to the services the provider is authorized to provide per a Medicaid participation agreement.

Providers are continually assessed to ensure that they conform to Medicaid participation standards and program policies. The provider is assessed on its ability to render consistent, high-quality care to individuals who are receiving services through the Commonwealth Coordinated Care Plus (CCC Plus) waiver. Information used to make this assessment may include desk reviews of the documentation submitted by the provider, on-site reviews of the provider's files, interviews with staff and with individuals during visits to their homes or place of residence, and by responses to quality assurance survey letters.

DMAS analysts will base an assessment of the provider on a comprehensive evaluation of the provider's overall performance in relation to the following program goals:

1. Individuals served by the provider meet the waiver program's eligibility criteria. If DMAS determines, during the QMR or at any other time, that the individual receiving waiver services no longer meets eligibility standards or criteria for waiver enrollment and services as set forth in DMAS regulations, the provider shall notify level of care staff within the DMAS Division of Aging and Disability Services (LOCreview@dmas.virginia.gov), and request that the provider discuss alternative services with the individual. The provider has a responsibility to be aware of the criteria for the waiver program and to evaluate, on an ongoing basis, the individual's appropriateness for waiver services.

2. Services rendered must meet the individual's identified needs and be within the program's guidelines. The provider is responsible for continuously assessing the individual's needs through home visits made by the provider and communication between the provider, services facilitator, provider staff, the waiver individual and/or primary caregiver. The provider must be notified of any substantial change in the individual's status, the individual's record must contain documentation of any such change, and additional orders must be obtained from the physician, if appropriate. This also includes the provider's responsibility to identify and make referrals for any other services that the individual requires to remain in the community (e.g., durable medical equipment and supplies, skilled nursing visits, etc.).

3. Provider documentation must support all services billed.

4. Services must be delivered by qualified individuals and providers as required and in accordance with the plan of care.

5. Services must be of a quality that meets the health, safety and welfare needs and the rights of the individual. Quality of care is best assured through an emphasis on communication and respect between the individual and provider staff, and between the individual and the providers who are responsible for the oversight of the plan of care. Some of the elements included in quality of care are:

    - Consistency of care;
    - Continuity of care;
    - Adherence to the person-centered plan of care; and
    - Consideration for the health, safety, and welfare needs of the individual.

6. The provider shall maintain a record for each individual. Forms that may be used are available on the Medicaid Web Portal at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home/

DMAS analysts will review the provider's performance in all outcome areas to determine the provider's ability to achieve high quality of care and conform to DMAS regulations and policies. The DMAS analysts are responsible for providing feedback to the provider regarding those areas that need improvement. DMAS analysts will work with the individual to evaluate the individual's status, satisfaction with the service, and appropriateness of the current Plan of Care (POC). If the POC is found to be inadequate, DMAS analysts may require a revision of the plan to meet the needs of the individual.

EXIT CONFERENCE

Following the DMAS analyst's or its contractors on-site review of the medical records and home visits, the DMAS analyst will meet during the exit conference with the appropriate provider staff to discuss general findings from the review. The provider may include any staff the provider would like to attend the exit conference, but must provide appropriate staff (as requested by the analyst) for this meeting. The Exit Conference is a courtesy meeting offered by DMAS. If the DMAS analysts determine that a face-to-face conference is not possible or not able to occur, the provider will be informed. The Exit Conference may be conducted face-to-face or by telephone, if necessary.

During the exit conference, the provider will be informed of the number of records reviewed, number of participants interviewed, general recommendations regarding level-of-care issues, general recommendations regarding the changes in Plan of Care documentation, and any pertinent information regarding documentation, service verification issues, quality of care, or provision of services. The

provider is expected to use the findings of the QMR review to comply with regulations, policies, and procedures in the future. Records that have been reviewed shall not be altered to meet the compliance issues. The DMAS analyst will send a letter to the provider verifying that the review was conducted. This letter will also describe the findings of the review or will give an update as to the status of the review. This letter will also include a list of any citations and technical assistance.

During the QMR review process, the DMAS analyst will be available to offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures. If questions arise regarding compliance issues, the analyst will provide information and assistance. Any uncorrected compliance issues may result in the termination of the provider contract.

ANNUAL LEVEL-OF-CARE REVIEWS

The federal regulations under which waiver services are made available mandates that every individual receiving services be reviewed each year to assure he or she continues to meet level-of-care criteria for the waiver's targeted population.

Providers will be required to submit documentation each year for review to DMAS at: LOCreview@dmas.virginia.gov, to demonstrate the individual's functional status and medical/nursing needs using the Level-of-Care Review Instrument. DMAS LOC review analysts will send the provider a letter each year indicating when the provider's level-of-care review is due and what documentation is required. For all agency-directed personal/respite care services, the level-of-care review must be completed by an RN. For all CD personal/respite care services, the level-of-care review must be completed by a CD Services Facilitator.

If it is found that an individual no longer meets the waiver level of care, DMAS will terminate services in accordance with the procedures detailed in Chapter IV of this manual.

DMAS can require repayment of overpaid money if providers continue to serve individuals who do not meet the level of care without notifying the service authorization contractor of the change in level of care and the need for discontinuation of services.

MEDICAL RECORDS AND RECORD RETENTION

The provider must recognize the confidentiality of individual medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern medical record use and removal and the conditions for the release of information. The individual's written consent is required for the release of information not authorized by law. Current individual medical record documentation and those of discharged individuals must be completed promptly. All clinical information pertaining to an individual must be centralized in the individual's clinical/medical record.

Records of CCC Plus Waiver services must be retained for six years from the last date of service and not less than six (6) years after the date of discharge. The provider must maintain medical records on all individuals in accordance with accepted professional standards and practice. The records must be

completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information. If the individual is under 18 years of age, his/her medical records must be retained not less than seven (7) years after the individual reaches age 18. All CCC Plus Waiver medical record entries must be fully signed and dated (month, day, and year), including the title (professional designation) of the author.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction of reimbursement.

DMAS or its contractors who conduct financial provider audits will coordinate with providers for any repayment for inappropriate reimbursement.

Section 32.1-325.1 of the *Code of Virginia* requires that DMAS collect identified overpayments. Repayment must be made upon demand unless a repayment is agreed to by DMAS. Unless a lump sum cash payment is made, interest will be added to the declining balance at the statutory rate pursuant to § 32.1-313 of the *Code of Virginia*. Repayment and interest will not apply for appeals that are in a pending status.

Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either Federal or State court. The program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

<u>Provider Fraud</u>

The provider is responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or

the signature of his or her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 East Main Street
Richmond, Virginia 23219

Recipient Fraud

The Recipient Audit Unit of DMAS investigates allegations about fraud or abuse by individuals. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of Medicaid card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

DMAS providers may refer Medicaid individuals suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of DMAS. Referred individuals will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program.

See the "Exhibits" section at the end of Chapter I of this manual for detailed information and forms on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate individuals on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, fax, or in writing. A toll-free HELPLINE is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: 1-804-786-6548
CMM HELPLINE: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the individual and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Refer to the end of Chapter I of this manual for the CMM Exhibits section.